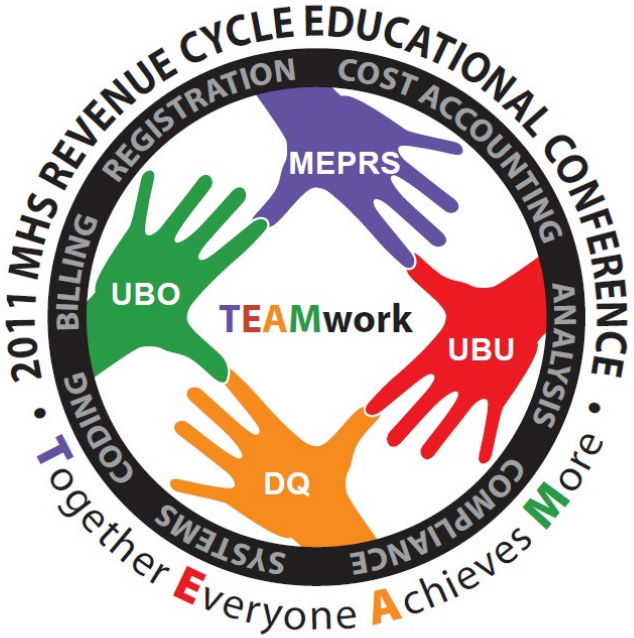


Title: **DRG Basics**

Session: **T-6-1000**

Objectives

- History of DRGs from inception to present
- Learn a basic understanding of coding guidelines
- Overview of Inpatient Coding
- Provide an overall understanding of the reimbursement process
- Impact of documentation on MS-DRG Reimbursement
- Importance of POA/HAC/SRE

Definitions

- MS-DRG – Medicare Severity Diagnostic Related Group
- Hospital – a health care institution
- Inpatient – hospital patient provided health care services, room and board and nursing services overnight
- Outpatient – patient who receives care without being admitted as an inpatient
- HAC – Hospital Acquired Condition
- POA – Present on Admission
- SRE – Serious Preventable Event

Background History

- Medicare Costs
  - Increased cost of hospital care
  - Hospitals paid under retrospective payment
    - Facilities were reimbursed for the total cost of providing patient care
- TEFRA (Tax Equity & Fiscal Responsibility Act) of 1982
  - Mandated Prospective Payment System
- Part of Prospected Payment System implemented in 1983
  - DRG Classification system used for classifying
    - Acute Care Patients
    - Measuring Case Mix Index

DRG Implementation

- Why were DRGs Implemented?
  - Reduce cost of patient care
  - Capture severity of illness
  - Improve payment accuracy
  - Measure resource consumption
  - Reduce profit for hospitals that treat less severely ill patients
  - Per-Case Payment

What is a DRG?

- Diagnosis Related Group (DRG)
  - Derived from all diagnoses & procedures listed in ICD-9-CM
  - Groups patients into categories that consume similar resources
  - Measures Case Mix Index
    - Frequency of admission of various types of patients
    - Reflects use of hospital resources
    - Identifies severity of illness (how sick patient population is)
  - Classified into 767 DRGs
  - DRGs
    - APR-DRGs
    - CMS-DRG
    - MS-DRGs

What is a DRG?

- Determines how much Medicare (other payers) reimburse the hospital for an Inpatient admission
  - Specific amount for each discharge based on one DRG
- Assignment is based on
  - Principal Diagnosis
  - Complication/Comorbidities
  - Principal Procedures
  - Other factors
- Updated annually in the Federal Register

What are DRGs used for?

- Determining the hospital reimbursement
- Budgeting
- Managed Care Contracts
- Physician profiling
- Determining hospital’s Case Mix Index

DRG Categories

- Principal Diagnoses divided into
  - 25 Major Diagnostic Categories (MDCs)
  - Medical or Surgical
  - Generally correspond to a single organ system
    - Example:
      - MDC 1 – Diseases and Disorders of the Nervous System
      - MDC 2 – Diseases of and Disorders of the Eye
- Number of DRG
  - Total of 767 DRGs for FY11

DRG Assignment

- Hospital Discharges
  - Only one DRG is assigned to each inpatient stay
- Assignment based on
  - Principal Diagnosis
  - Secondary Diagnosis
  - Principal Procedures
  - Age, Sex, & Discharge Status
- Each DRG has a relative weight
  - Example: DRG 001 – 26.34
  - Higher weight = greater resource consumption
  - Used to calculate reimbursement for hospitals

DRG Reimbursement

- Hospitals are paid a set fee for treating patients based on DRG assignment
- Payment is set regardless of the actual cost of the patient's stay
- Weight assigned based on resource consumption
- Reimbursement = hospital base rate x DRG weight

Payers

- Medicare
- TRICARE
- Medicaid
- Blue Cross/Blue Shield
- Self-Pay
  - May change to MC or Medicaid

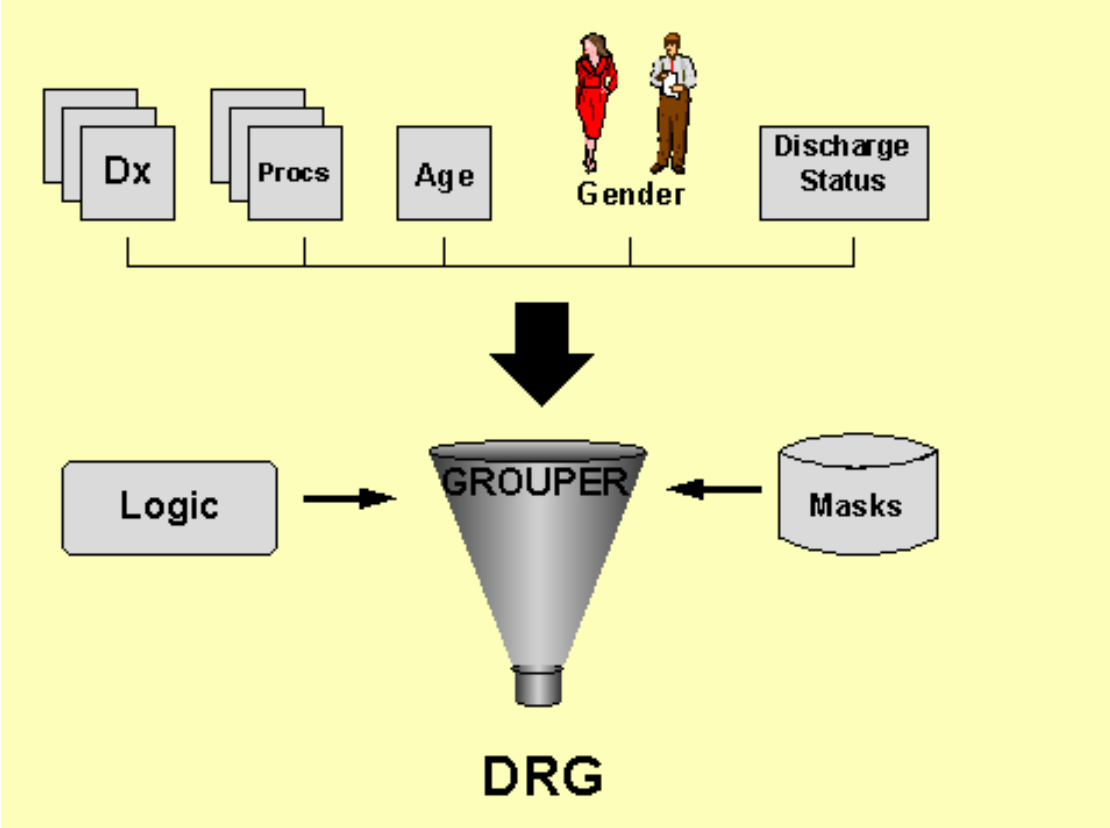
DRG Computation

- Grouper
  - A program or module that takes 5 clinical demographic data elements as input and gives a corresponding DRG as output
- DRG Drivers
  - Principal Diagnosis
  - Secondary Diagnosis (CC or MCC)
  - Principal Procedure
  - Sex of the patient
  - Discharge Status (Very Important)

Role of CC/MCC

- Complication/Comorbidities
  - CMS developed a list of CC/MCC conditions that impact MS-DRG assignment
  - CMS determines whether a condition will stay as MCC or reassign as a CC
  - DRG assignment factor
    - CC – Complication or Co-morbidity
    - MCC – Major Complication or Co-morbidity
      - Example: Sepsis

Grouper Example



TRICARE DRG Example

MS-DRG	Principal	Procedure	Wt & A/LOS	Est. Reimb	Trf. DRG
395 – Other Digestive System Diagnosis w/o CC/MCC	Acute Appendicitis	No Procedure	TRICARE Wt: 0.7223 A/LOS: 2.8	$3865.36 (Discharged Home)	$3 ,865.36 (Transferred-Short Term Acute)
343 – Appy w/o Comp. PDX w/o CC/MCC	Acute Appendicitis	Appy	TRICARE Wt: 0.9932 A/LOS: 1.6	$5,315.07 (Discharged Home)	$5,315.07 (Same as above)
341 – Appy w/o Comp PDX w/MCC	Acute Appendicitis Secondary DX: Pneumonia	Appy	TRICARE Wt: 1.6428 A/LOS: 3.6	$8,791.38 (Discharged Home)	$8,791.38 (Same as above)

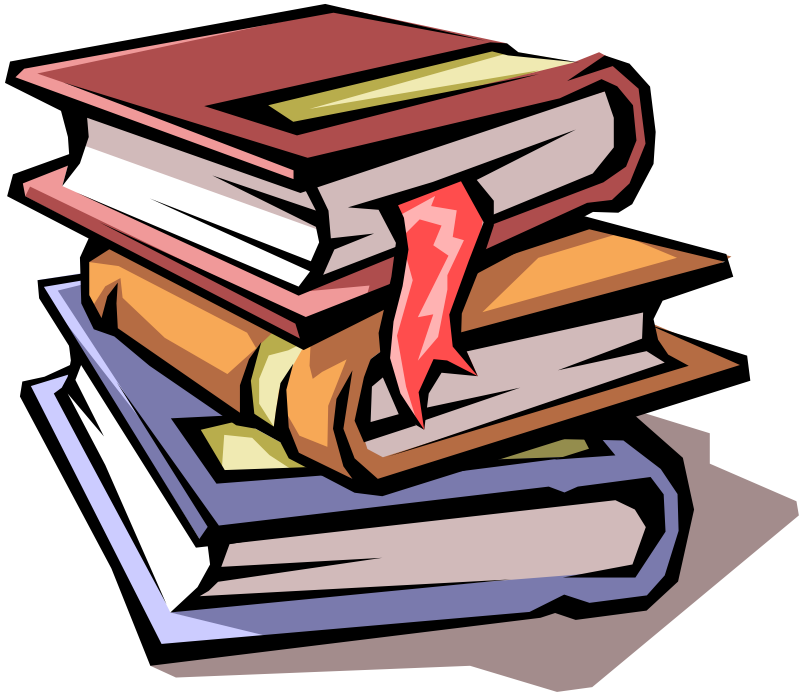
Note: Reimbursement rate is different for Non-TRICARE DRGs

What Is Coding?

- A collection of information regarding diseases and injuries
- Used for clinical research
- Reimbursement
- Validate data for registries (Cancer, Trauma)

Types of Coding

- Inpatient
- Outpatient
- Ambulatory Surgical Coding
- Physician Coding
- Rehabilitation
- Long Term Care



Inpatient vs. Outpatient Coding

- Inpatient
  - MS-DRG's
  - Inpatient Coding Guidelines
  - ICD-9-CM Coding Book
  - Coding Clinics
- Outpatient
  - APC's
  - Outpatient Coding Guidelines
  - ICD-9-CM Codebook
  - CPT Codebook
  - HCPCS

Coding Guidelines

- Cooperating Parties
  - American Hospital Association
  - American Health Information Management Association
  - Center for Medicare & Medicaid Services (formerly known as HCFA – name changed since 2002)
  - National Center for Health Statistics
- MHS Cooperating Parties
  - UBO/UBU

Coding Guidelines

- Cooperating Parties Main Duties
  - Develop Official Coding Guidelines for ICD-9-CM Coding
  - Guidelines Published on the National Center for Health Statistics Web site
    - http://www.cdc.gov/nchs/data/icd9/icdguide.pdf
- MHS Coding Guidelines
  - Published on TMA Web site
    - http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm

Learning Inpatient Coding

- Familiarize yourself with ICD-9-CM coding book
  - Tabular & Index of Diagnosis (Vols. 1 & 2)
  - Tabular & Index of Procedures (Vol. 3)
  - Faye Brown Coding Handbook
  - Coding Clinics
- Review Coding Conventions and Instructional notes
  - Examples:
    - NEC (Not Elsewhere Classified), Omit Code, Code First Underlying Condition, Symbols
- Learn Official Coding Guidelines
  - Read and re-read
  - Updated every year

Learning Inpatient Coding

- Codes updated twice yearly
  - October 1
  - April 1 (New technology)
- Coding Clinic
  - Official publication for ICD-9-CM coding guidelines and advice for all healthcare settings
  - Published quarterly by the American Hospital Association
    - Example provided in background slides

Learning Inpatient Coding

- Documentation Specifics
  - Uniform Hospital Discharge Data Set (UHDDS)
    - Improve uniformity of hospital discharge data
    - Used in non-outpatient facilities
  - UHDDS and Coding
    - Includes medical data items for diagnoses and procedures
    - Includes definitions explaining sequencing of what is reported

UHDDS Elements

- UHDDS Definitions
  - Principal Diagnosis
    - The condition established “after study” to be chiefly responsible for the admission of the patient to the hospital
  - Other Diagnosis
    - Conditions that co-exist at the time of admission or develop after and/or affect the patient care during the stay
  - Admitting Diagnosis (Not an element of UHDDS)
    - Must be reported for some payers and is useful for quality of care studies
  - Significant Procedures
    - Surgical in nature
    - Carry an anesthetic or procedural risk
    - Requires specialized training

Principal Diagnosis

- Selecting the Principal Diagnosis
  - Drives DRG Assignment
  - Important for appropriate reimbursement
  - Depends on circumstances of admission
  - Why was patient admitted?
  - Attending physician is ultimately responsible for the principal diagnosis or any other documented diagnoses
  - Diagnosis “After Study”

Principal Diagnosis

- What is meant by “after study”?
  - Confused?
  - Words are important in the definition of the principal diagnosis – incomplete documentation can alter the application of the coding guidelines
  - In a nut shell
    - It is not the admitting diagnosis
    - But rather the diagnosis after work up or surgery
    - That proves to be the reason for admission

Principal Diagnosis

- Selecting Principal Diagnosis “after study”
  - Example:
    - If a patient presents to the hospital complaining of right lower quadrant pain
    - He is admitted for workup, WBC count is slightly elevated, palpation signs are positive and “after study,” he is diagnosed with probable acute appendicitis
    - Principal Diagnosis is?
      - Acute Appendicitis

Other Diagnoses

- Secondary/Other/Additional Diagnoses
  - UHDDS Definition:
    - “All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.”
    - For reporting purposes these are other conditions that affect patient care and extend the hospital stay

Other Diagnoses

- Secondary Diagnosis
  - Example:
    - Our Appendicitis patient develops a bad cough
    - Chest x-rays are taken and patient is diagnosed with pneumonia
    - Pneumonia is reported as an additional diagnosis but is not the PDX because the reason for admission was the appendicitis

Other Diagnoses

- Complication
  - Condition that develops after admission affecting treatment and/or length of stay
    - Example: Pneumonia
- Co-morbidity
  - Coexisting conditions at the time of admission affecting the treatment and increases length of stay (chronic conditions)
    - Example:
      - Diabetes
      - Hypertension

Principal Procedure

- Principal Procedure
  - Procedure performed for definitive treatment, rather than for diagnostic or exploratory purposes or one that takes care of a complication
    - Usually related to the principal diagnosis
      - Example:
        - Diagnosis: Acute Appendicitis
        - Principal Procedure: Appendectomy

Inpatient Coding

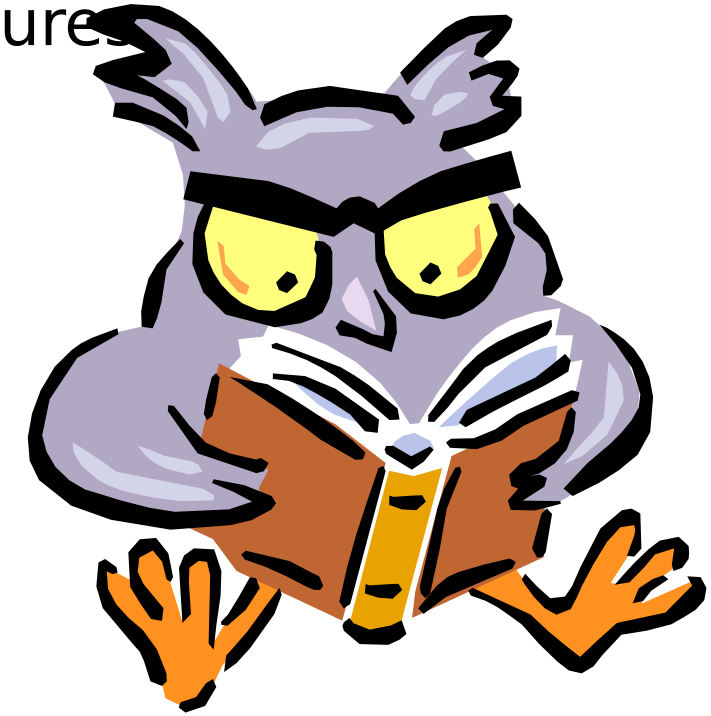
- Resources for Coding an Inpatient Chart
  - International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Code Book(Volumes 1, 2, and 3)
  - Coding Clinics
  - Encoder Grouper
  - Abbreviation Book
  - Medical Dictionary
  - Hospital Inpatient Coding and Compliance Policy

Inpatient Coding

- Review entire record
  - From Admission to Discharge
- Validate
  - Admission Order
  - Discharge Status
- Review
  - Discharge Summary
  - Physician Orders
  - History & Physical
  - Progress Notes
  - Consultations
  - Operative or Pathology Reports

Inpatient Coding

- Create a picture of the patient's stay
  - What was reason for admission?
  - What was patient treated for?
  - What was patient diagnosed "after study"?
  - Establish principal and secondary diagnoses
  - Were there any procedures



Inpatient Coding Services

- Inpatient Process
  - Patient Admitted
  - Care Is Rendered
  - Patient Is Discharged
  - Coder Reviews Record
  - Record Is Coded and Finalized
  - Bill Sent Out Electronically
  - Hospital Receives Reimbursement
    - If no denials are received

Denial Management

- Reasons for Denials
  - Diagnosis provided does not meet medical necessity
  - Lack of certification or length of stay authorization
  - Wrong code assignment
  - Duplicate claims
  - Past filing deadline

Denial Management

- Coding Impacts Reimbursement
- Accurate coding is the key
- Coding is complex for both inpatient and outpatient
  - Constant changes in rules and regulations
- Physician documentation is vital
  - Documentation in the medical record should be comprehensive and complete
  - Be timely
  - Legible (except in electronic format)
- Coder Education
- Team Effort – Admitting/Medical Records/Billing

Other Factors Affecting DRGs

- Present on Admission (POA)
  - Implemented based on Deficit Reduction Act of 2005
  - Required hospitals to report secondary diagnoses with a POA indicator
    - POA Indicators
      - "Y"-Yes, "N"-No, "U"-Unknown, "W"-Clinically Undetermined, and "1/Blank"-Exempt from POA reporting
    - Acute Care Hospitals under IPPS
  - Does not change DRG but affects reimbursement
    - DRG reimbursement is adjusted – they do not pay
    - If secondary conditions are not POA, then CMS treats as if they were not reported

Other Factors Affecting DRGs

- POA Key Points
  - Conditions present on admission at time order is written
  - Distinguishes between pre-existing conditions and hospital acquired conditions (HACs)
  - Applies to principal and secondary diagnoses
  - No required timeframe for provider to identify or document conditions as POA
  - Coordinated effort between coder and providers for accurate documentation
  - If documentation is ambiguous
    - QUERY, QUERY, QUERY the physician for clarification
  - Develop policy, educate providers and coders, create query forms

Other Factors Affecting DRGs

- Hospital Acquired Conditions (HAC)
  - Conditions that develop after inpatient hospital stay
  - Selected conditions
    - High cost and/or high volume
    - Result in DRG have higher payment when present as secondary diagnosis
    - Could have been preventable
  - Reimbursement is adjusted if HAC is not POA
  - HAC Examples:
    - Foreign Object retained after surgery (CC)
    - Falls & Trauma (CC/MCC)
    - Pressure Ulcer Stages III & IV (MCC)
    - Infections following certain Orthopedic Procedures (CC)
    - Blood Incompatibility (CC)
      - FY2011 – expanded 999.6 to 999.60-63 and 999.69

Other Factors that Affect DRGs

- Serious Reportable Events
  - Also known as “never events”
  - CMS reduced payment
    - some SREs included in HACs list
  - CMS introduced non-coverage decisions on three “wrong surgery events” – SREs
  - E-codes that identify “wrong surgery” performed on a patient and are required to be reported
    - E876.5 - wrong operation/procedure on correct patient
    - E87.66 - operation/procedure on patient not scheduled for surgery
    - E876.7 - correct operation/procedure on wrong side or body part

Other Factors that Affect DRGs

- Serious Reportable Events (cont'd)
  - Joint Commission approved Universal Protocol for Preventing these SREs
    - Conducting a pre-procedure verification process
    - Marking the procedure site
    - Taking a "time out" immediately before the start of the procedure

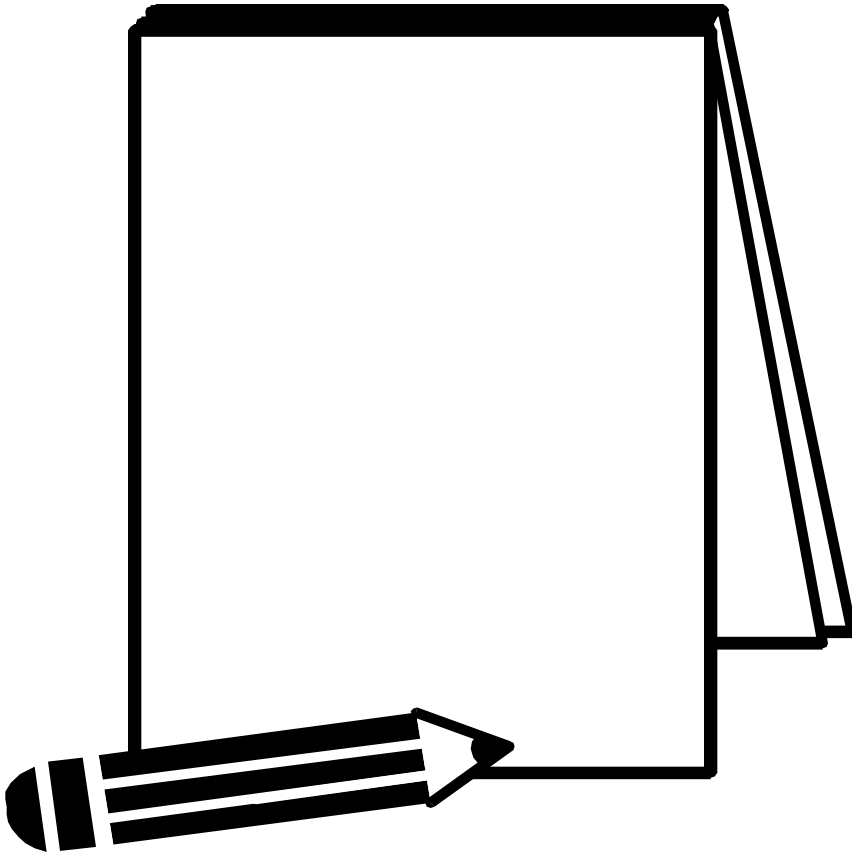
Education

- Review & Re-review Official Coding Guidelines, MHS Coding Guidelines, applicable coding compliance plans
- Familiarize yourself with Faye Brown Coding Handbook, ICD-9-CM Coding Book, Anatomy and Physiology and Medical Terminology Books
- Understand Present on Admission (POA) Guidelines and Reporting; differentiate between conditions present on admission and those that developed after Inpatient admission (HAC) and SRE
- Coordinated effort between providers, clinical staff, and coders to ensure accurate documentation
- Emphasize importance of physician documentation and how it affects reimbursement, patient quality of care

What's in the Future?

- TMA established a committee in preparation for MHS conversion to ICD-10-CM
- Coder Education
  - AHIMA
  - AAPC
- ICD-10-CM Implementation
  - October 1, 2013

Any Questions?



Background Slides

Coding Clinic Example

- CC, 4th QTR 2009 page 150
  - A patient is being seen for home care for dressing changes for treatment related to a healing stage III pressure ulcer of the heel. How should this encounter be coded?
  - Assign code V58.30 encounter for change or removal of non-surgical wound dressing as the first listed code. In addition, assign coded 707.07 pressure ulcer, heel; and 707.23, pressure ulcer stage III, for the pressure ulcer. According to the Official Guidelines for Coding and Reporting "Aftercare codes should be used in conjunction with any other aftercare codes or other diagnosis codes to provide a better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes is discretionary."

References

- “Guide to Outpatient Clinical Documentation Improvement: First Step in Revenue Cycle Management,” Ruthann Russo, JD MPH, RHIT, 2003
- “Coding and Reimbursement for Hospital Inpatient Services,” Karen S. Scott, Med, RHIA, CCS, 2006
- “Faye Brown’s ICD-9-CM Coding Handbook,” 2010
- “ICD-9-CM Official Guidelines for Coding and Reporting,” 2010
- “Medical Necessity: What, Why and How?” Lenore M. Whalen, RHIT, CCS, CCS-P, AAHIMA 2nd Qtr Meeting, 2006
- Coding Clinic
- CMS Web site
- AHIMA, “Understanding National Coverage Policies,” Jane Cook, CPC, Cheryl D’Amato, RHIT, CCS et al., June, 2009